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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/18/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Inpatient right total knee replacement

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Adverse determination notice 05/21/12
Adverse determination after reconsideration notice 06/19/12
Progress notes Dr. 08/22/10-04/30/12
Post arthrographic MRI right knee 07/20/11
X-rays right knee 08/16/11
MRI right knee 03/04/11 and 11/10/10
Operative reports right knee arthroscopy 11/08/11, 03/29/11, and 12/21/10
Physical therapy daily notes 01/12/11-02/06/12
Office notes Dr. 10/13/10-03/07/11
Carrier response to request for IRO 07/03/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female whose date of injury is xx/xx/xx. The claimant stated she was standing and some trays fell on her right knee. She is status post right knee arthroscopy x 3 (12/02/10, 03/29/11, and 11/08/11). The claimant continued to complain of right knee pain. Progress note dated 04/30/12 indicates the claimant has tried and failed conservative treatment consisting of arthroscopy, physical therapy, bracing, cortisone injection, and visco injection. She is reported to have evidence of tricompartmental chondromalacia, and total knee replacement was recommended.

A preauthorization request for inpatient right total knee replacement was denied on utilization

review dated 05/21/12 noting that there does not appear from operative note, MRI and plain film x-ray evidence of at least significant osteoarthritis in 2 or 3 compartments with grade IV chondromalacia in one compartment only.

A reconsideration request for inpatient right total knee replacement was non-authorized on utilization review dated 06/19/12 noting imaging showed chondromalacia and mild arthritis without indication on op note or imaging of extensive multiple compartment degenerative joint disease with osteophytes, joint space narrowing, bony sclerosis.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical information provided, medical necessity is not established for proposed inpatient right total knee replacement. The claimant sustained an injury to the right knee on xx/xx/xx and subsequently underwent right knee arthroscopy x 3. She continued to complain of right knee pain. Records indicate she failed conservative treatment including physical therapy, bracing, cortisone injection, and viscosupplementation. Progress note dated 04/30/12 indicates the claimant has evidence of tricompartmental chondromalacia as seen during last arthroscopy. However, the operative report dated 11/08/11 noted only grade IV chondromalacia in medial compartment. As noted on previous reviews, there is no objective evidence of extensive multiple compartment degenerative joint disease. The documentation provided does not support a determination of medical necessity for right total knee replacement, and previous denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)